EDITORIAL

Reiter's disease is characterized by a clinical syndrome consisting of a primary abacterial urethritis of venereal origin, bilateral conjunctivitis, polyarthritis, frequently balanitis, and sometimes keratodermia blennorrhagica. There is an almost identical syndrome associated with the various types of dysentery (the primary infection in these cases being in the bowel, not the urethra) which is probably the same disease. The syndrome may be complete or incomplete. The disease may simulate arthropathic psoriasis, acute rheumatism (in adults), ninth-day erythema, or the syndromes of Stevens, Johnson, and Behcet. The venereal syndrome was first described by Sir Benjamin Brodie in 1818 and the dysenteric syndrome by Caelius Aurelianus at the beginning of the 5th century A.D. It is unfortunate that the disease bears Reiter's name. The one case described by him in 1916 occurred during the acute phase of an attack of dysentery (Reiter, 1916). Most, if not all, of the cases reported in the British Isles are venereal in origin.

There are two papers in the present issue, one by Cameron (p. 7) reporting two cases of keratodermia blennorrhagica and the other by Fowler and Knight (p. 2) concerning the value of treatment in Reiter's disease. The aetiology of Reiter's disease is unknown and, while the cause of the condition remains in doubt, we can hardly expect treatment to be set on a sound footing. Fowler and Knight review the literature and assess the effects of treatment in seventy cases. They conclude that no treatment at present in use has any influence on the course of the disease. Ford (1953) also stated that the underlying cause of the disease is in no way affected by any treatment at present available and that only temporary suppression of the clinical symptoms can be achieved by ACTH or cortisone. There are, however, workers in this field who are not quite so pessimistic. King and his collaborators (1946) and Harkness (1945) have obtained good results with fever therapy. Harkness (1953) obtained excellent results with terramycin in early cases (24 hours' duration). In two further cases, in which blood-borne complications developed during courses of aureomycin, there were complete and dramatic recoveries with terramycin. In this respect it is interesting to note that Fowler and Knight report four cases, in all of which there was a previous history of the disease, where the syndrome developed during courses of terramycin. Treatment with terramycin in established cases, and indeed all other treatments, is unpredictable. There are many, however, who consider the treatment of choice to be terramycin or tetracycline combined with fever therapy.

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